NORTH BAY FOOT & ANKLE CENTER
PATIENT FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions please discuss them with our front office staff.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in our office.
- Unless you or your health carrier has other arrangements in advance, payment for office services is due at the time of service. We will gladly accept VISA, MASTER CARD, DISCOVER, AMERICAN EXPRESS, CASH, or CHECK.
- We have made prior arrangements with insurers and other health plans to accept an assignment of benefits. We will bill those plans with whom we have an agreement and will only require you to pay the co-pay/coinsurance/ deductible at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered" or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services: however, you remain responsible for charges for any services rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all insurance changes, address changes, employment changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any denied charges.
- There are certain procedures that required pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due at the time of visit.
- Past due accounts are subject to collection proceedings. All fee including, but not limited to collection fees, attorney fees and court fee shall become your responsibility in addition to the balance due for this office.

There is a fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Please notify our office within 24 hours of your scheduled appointment if you need to reschedule or cancel. Otherwise, a $50.00 fee will apply for no-show appointments.

I have read and agree to the terms of this financial agreement.

Signature of Patient/ Responsible Party: _____

Printed Name: _____ Date: _____